Strafford County Drug Treatment Court
ADMISSION APPLICATION

Docket # _____

Name: _____Age:_____ DOB: _____ Race: _____

Address: _____Town: _____ ZIP_____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Email Address: _____

Emergency Contact: _____Relation:_____Phone:_____

Social Security Number: _____/_____/_____ Are you a US citizen? _____

Family and relationships:

Please name and give the relationships of supportive people in your life right now:

_____

_____

Marital Status: _____ Spouse Name/Significant other: _____

Do you have children: Y or N (circle one) If yes, how many: _____

Please list name and ages: _____

_____

Are you financially supportive of your children: Y or N Do you receive child support: Y or N

Living:

Time at current residence? _____ Number of times moved this past year? _____

Name, age and relationship of persons living with you: _____

_____

_____

Criminal History:

Are you facing new felony or misdemeanor charges? _____

Are you facing a probation or parole violation? Y or N

List initial charges/offenses: _____

Next court date that you are aware of: _____ Location: _____

Attorney's name: _____ Address: _____

Phone number: _____ Fax number: _____

Prosecutor's name: _____ Phone: _____

Adult Charges:	Date:	Convicted: Yes / no	Sentenced/Court:

_____

_____

_____

_____

Pending charges in this or any other state? Y or N

If yes, please explain: _____

_____

Prior Probation/Parole: Y or N (If yes, please fill in dates, county and any violations).

Dates:	County:	Violations of probation:

_____

_____

_____

Are you or have you been on probation or parole: _____ If Yes who was your PPO?_____

State you are on Probation or Parole in: _____

Education:

Highest level of education (for example: high school diploma, GED, bachelor's degree, trade school:

_____ Where? _____

Have you ever been diagnosed with a learning disability? Y or N

If yes please explain_____

Have you taken any college classes? _____

Have you seen a vocational counselor before? Y or N

Employment:

Current Employer: _____ Employer Phone #: _____

Supervisor's name: _____ Length of time employed there: _____

Job title: _____ Job duties: _____

Unemployed_____ How long_____ Reason_____

Disability:

Do you receive Disability benefits: Y or N

If yes, what type: _____

Insurance

Do you have health insurance? Y or N

If you have health insurance; name of insurance: _____

Are you on Medicare/Medicaid? Y or N Do you have a primary physician? Y or N

Medical:

Do you have any medical problems that restrict your activities? Y or N

Explain: _____

Are you presently on prescriptions for medical reasons? _____

If yes, please name them and the dosage_____

Reason for medication? _____

Date of last physical _____ Where was the physical_____

Mental Health:

Have you ever sought treatment for a mental illness? Y or N If yes please explain_____

_____

Where and when did you receive treatment for mental illness? _____

_____

Have you ever been diagnosed with a mental illness? Y or N If yes please explain_____

_____

Are you currently on medication to help manage mood, anxiety, depression or any other symptoms?

Y or N

If so, which medication and dosage:

_____

What are the medications targeted to treat?

_____

Have you ever been prescribed medications for mental health reasons? _____

What medication? _____ For what? _____

_____

Have you ever seen a Psychiatrist before? Y or N If yes please explain_____

_____

History of Suicidal or Homicidal attempts or ideations Y or N If "yes" please explain: _____

_____

Driving

Do you currently possess a drivers license? Y or N What state? _____

Do you have any pending issues with your license? Y or N If yes please explain_____

_____

Have you ever lost your drivers license? Y or N If yes please explain_____

_____

If you do not possess a drivers license, why did you lose it and what will it take for you to get it back?

_____

_____

Substance Use

Prior Treatment/Counseling/Self-Help meeting attendance? (Please list dates and places):

_____

_____

_____

My Primary Drug(s) of choice is/are: _____

My Drug(s) of abuse is/are: _____

Age of first use for each substance: _____

Date(s) of last use of each substance: _____

How often and what quantity are/were you using of each substance: _____

_____

Drug Court Goals:

The Drug Treatment Court is an alternative sentencing program for individuals who possess a desire to make life/behavioral changes. Are there any changes you believe you need to make at this point and time in your life?

_____

_____

_____

_____

_____

The Drug Treatment Court also focuses on many areas of life skills such as financial,

employment, parenting and relationships. What skills do you need help with and what do you hope to learn?

_____

_____

_____

_____

_____

What do you hope to accomplish in this program? What are your goals?

_____

_____

_____

_____

_____

Why do you believe you should be admitted and ordered to the Drug Treatment Court*?*

_____

_____

_____

_____

_____

After your application has been received and reviewed you will be contacted by Southeastern NH Services to set an appointment for an alcohol and drug assessment.

I understand that I must mail or drop off this application to Carrie Conway or Chris Gowell with my signature at the bottom.

I certify that the above information is correct to the best of my knowledge.

*I also understand that as part of my Drug Court application and admission procedure that there will be discussions between Drug Court team staff including but not limited to; Probation/Parole Officer, Judge, Prosecutor, Clerk, and Defense Attorney. I grant permission for these discussions to take place to assist in determining my eligibility for Drug Court.

_____ _____

Client signature Date

_____ _____

Attorney signature Date

Please mail or drop off the application to the address below. The office is located in the basement area in the Superior Court Building: Community Corrections.

Carrie Conway, MSW, Coordinator
Or
Chris Gowell, BS, Director
Strafford County Drug Treatment Court
259 County Farm Road, Unit 103
Dover, NH 03820

SOUTHEASTERN NEW HAMPSHIRE SERVICES
272 COUNTY FARM ROAD
DOVER, NH 02820
(603) 749-3981

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I,_____, authorize Southeastern NH Services to disclose treatment information, as described below, to the Strafford County Drug Treatment Court, Strafford County Attorney's Office, the New Hampshire Public Defender's Office and the N.H. Department of Corrections, Probation & Parole Division. Please initial below.

_____Strafford County Drug Treatment Court
259 County Farm Road Unit#103
Dover, NH 03820
603-516-7193

_____Strafford County Attorney's Office
P.O. Box 799
Dover, NH 03821-0799
603-749-2808

_____New Hampshire Public Defender's Office
50 Chestnut Street
Dover, NH 03820
603-749-5540

_____N.H. Department of Corrections/Probation & Parole Division
259 County Farm Road
Dover, NH 03820
603-742-6621

I give my permission to release all treatment program information relevant to my risk to experience further alcohol/drug related problems. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records., **42 CFR Part 2,** and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that although I may revoke this consent at any time, revocation of this consent will subject me to termination from the Strafford County Drug Treatment Court Program. This consent expires automatically on the date that I fully complete the Strafford County Drug Treatment Court Program.

_____ _____
Signature of Participant Date

Strafford County Drug Treatment Court

259 County Farm Road Unit#103, Dover NH 03820 (603) 516-7193

Consent for the Release of Confidential Information

I, _____ authorize the Strafford County Drug Treatment Court to disclose information as described below, to the following institutions: Please initial all below.

____Strafford County HOC
____All law enforcement agencies (including local Police, State Police, and NH Drug Task Force)
____My attorney
____NH Department of Corrections Probation/Parole
____Strafford County Community Corrections
____All relevant courts
____NH County Attorney
____Community Partners
____ARC Program
____Southeastern NH Services
____Farnum Center
____Hampstead Hospital
____Headrest
____Friendship House
____Phoenix House
____Serenity House
____Tirrell House
____Webster Place Recovery Center
____Seacoast Mental Health Center
____Families First
____Turning Point
____Catholic Charities
____My Friend's Place
____My Medical Doctor or Prescribing Physician
____Goodwin Community Health
____Place of employment/supervisor
____My dentist or prescribing dental institution
____My spouse/significant other
____R.O.A.D to a Better Life
____ Program evaluators, Employees of the NH Center for Public Policy (for the sole purpose of program evaluation).

The purpose of this disclosure authorized herein is to help facilitate in the assessment, placement, supervision and sentencing of the Strafford County Drug Treatment Court.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Until successful completion or termination of the Strafford County Drug Treatment Court and Probation
(Specification of the date, event or condition upon which this consent expires)

_____ _____
Signature of Participant Date

Requirements to Participate in the Strafford County Drug Court Program

I, _____, have read and understand the requirements listed below for me to be a participant in the Strafford County Drug Court Program.

1. _____ I must be a resident of Strafford County.
2. _____ I understand that Drug Court is a (minimum of) one year long program and after I graduate I will have a year of probation to complete.
3. _____ After I graduate the Drug Court Program, I will be required to attend the Continuing Care group for a minimum of 22 weeks. It meets once every other week for 1 ½ hours. It will coincide with your last year of probation.
4. _____ In the beginning phase of Drug Court, I will be required to attend Drug Court sessions once a week.
5. _____ In the beginning phase of Drug Court, I will be required to attend Individual Outpatient Group Therapy Mon, Tue, Wed, and Thu from 4:30-7:30 P.M.
6. _____ In the beginning phase of Drug Court, I will be required to attend individual counseling sessions once per week.
7. _____ I understand that I will have a Drug Court fee to pay for my urine testing. The fee starts at $30 / week and is based on my drug test results.
8. _____ I understand that I will be drug tested at least 3 times per week. Two scheduled tests and at least one random test.
9. _____ I understand that probation will be conducting home visits at my place of residence.
10. _____ I will be required to start the program the day I plead into Drug Court.

_____ _____

Signature Date